Deductibles \$325/650/576 \$325/650/576 \$500/651,000 \$51,000 \$2,000 \$54, 000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$54,000 \$50,000 \$54,0	BLUE CROSS BLUE SHIELD NM - PPO		BLUE CROSS BLUE SHIELD NM - HMO	PRESBYTERIAN - HMO				
Date of Pockets (-embest-transmora table)	EFERRED PROVIDE	PREFERRED PROVIDER			BENEFITS			
Lifetime Maximum	0 / \$5,600 / \$8,400	\$500 / \$1,000 / \$1,500	\$325/\$650/\$975	\$325/\$650/\$975	Deductibles			
Primary Care Provider \$25.00 (deductible walved) \$25.00 (deductible walved) \$50.00	/ \$14,000 / \$21,000	\$3,500 / \$7,000 / \$10,500	\$3500/\$7000/\$10500	\$3500/\$7000/\$10500	Out of Pocket (combined Pharmacy & Medica			
Specialist Provider		Unlimited	Unlimited	Unlimited	Lifetime Maximum			
Adult Preventive Services	50%	\$30 (deductible waived)	\$25.00 (deductible waived)	\$25.00 (deductible waived)	Primary Care Provider			
Well Child Services S0 (deductible waived) \$0 (deductible waived)	50%	\$50.00	\$40.00	\$40.00	Specialist Provider			
Laboratory	deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	Adult Preventive Services			
Name	deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	\$0 (deductible waived)	Well Child Services			
Inpatient Hospital	50%	20%	20%	20%	Laboratory			
MRI/PET/CT Scane 20% up to maximum of \$200 per test 20% 20% 35%	50%	20%	20%	20%	X- Ray			
Outpatient Surgery 20% 20% 20% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 35% 30% 30% 35% 30% 35% 30% 35% 30% 30% 35% 30% 30% 35% 30% 3	50%	\$1,000.00 per admission	\$500.00 per admission	\$500.00 per admission	Inpatient Hospital			
Maternity Physician Services \$25.00 Initial Visit Only \$25.00 Initial Visit Only \$30 Initial Visit Only \$50	50%	20% up to maximum of \$200 per test	20% up to maximum of \$200 per test	20% up to maximum of \$200 per test	MRI/PET/CT Scans			
Maternity Hospitalization	50%	20%	20%	20%	Outpatient Surgery			
Routine Nursery Care for Newborns No Copay No Copay No Copay Signature	50%	\$30 Initial Visit Only	\$25.00 Initial Visit Only	\$25.00 Initial Visit Only	Maternity Physician Services			
Emergency Room Visit	50%	\$1,000.00	\$500.00	\$500.00	Maternity Hospitalization			
Urgent Care Center	50%	No Copay	No Copay	No Copay	Routine Nursery Care for Newborns			
Mental Health Out Patient \$25.00 \$25.00 \$30.00 \$50.	\$175.00	\$175.00	\$175.00	\$175.00	Emergency Room Visit			
Montal Health in Patient S500.00 S40.00 (up to 25 combined visits per plan year) Naprapathic Services S50.00 (up to 550.00 (up to 550.00 per plan year) Naprapathic Services S50.00 (up to 550.00 per plan year) S50.00 (up to 55	\$50.00	\$50.00	\$50.00	\$50.00	Urgent Care Center			
Chiropractic, Acupuncture S40.00 (up to 25 combined visits per plan year) Naprapathic Services S50.00 (up to 5500 per plan year) S50.00 (up to 5500 per	50%	\$30.00	\$25.00	\$25.00	Mental Health Out Patient			
S40.00 (up to 25 combined visits per plan year) (up to 25 combined per plan year) (up to 25 combined visits per plan year) (up to 25 visits combined per plan year) S50.00 (up to \$500 per yer per plan year) S50.00 (up to \$500 per yer per plan year) S50.00 (up to \$500 per yer per	50%	\$1,000.00	\$500.00	\$500.00	Mental Health In Patient			
Chiropractic, Acupuncture (up to 25 combined visits per plan year) Naprapathic Services S50.00 (up to \$500 per plan year) S50.00 (up to \$500	50%	\$50.00	640.00	£40.00				
Naprapathic Services S50.00 (up to \$500 per plan year) S50.00 (up to \$500 per year	25 visits combined	(up to 25 visits combined per plan	•	•	Chiropractic, Acupuncture			
Durable Medical Equipment Chemotherapy and Radiation Therapy Home HealthCare S40.00 Physician, no copay for nursing services No Copay in Physicians Office S40.00 Physician, no copay for nursing services No copay up to \$2500 per yr per ear, once every No copay up to \$2500 per yr per ear, once every 3 yrs Speech Therapy Hospice No Copay Sexpress Scripts Inc - Pharmacy Bonefit Manager Retail 30 Day Supply Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill Home Delivery Specialty III Accredo 2 retail fills them Delivery No Day Supply	er plan vear)	vear)	(up to 25 combined visits per plan year)	(up to 25 combined visits per plan year)				
Chemotherapy and Radiation Therapy Home HealthCare S40.00 Physician, no copay for nursing services Hearing Alds No copay up to \$2500 per yr per ear, once every 3 yrs No copay up to \$2500 per yr per ear, once every 3 yrs Physical, Occupational, & \$40.00 Speech Therapy Hospice No Copay Sexpress Scripts Inc - Pharmacy Benefit Manager Retail 30 Day Supply Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill Home Delivery Rome Del	to \$500 per plan ye	\$50.00 (up to \$500 per plan yer)	\$50.00 (up to \$500 per plan year)	\$50.00 (up to \$500 per plan year)	Naprapathic Services			
Radiation Therapy Home HealthCare \$40.00 Physicians, no copay for nursing services \$40.00 Physician, no copay for nursing services Hearing Alds No copay up to \$2500 per yr per ear, once every 3 yrs Physical, Occupational, & \$40.00 Speech Therapy Hospice No Copay Speech Therapy Home Delivery Specialty Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill No Copay in Physicians Office \$50.00 S50.00 S50.00 S50.00 S50.00 Specialty Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill	40%	25%	20%	20%	Durable Medical Equipment			
Home HealthCare \$40.00 Physician, no copay for nursing services No copay up to \$2500 per yr per ear, once every 3 yrs Physical, Occupational, & \$40.00 \$40.00 \$40.00 \$5	50%	\$50.00	No Conay in Physicians Office	No Copay in Physicians Office	Chemotherapy and			
Hearing Alds No copay up to \$2500 per yr per ear, once every 3 yrs Physical, Occupational, & \$40.00 Speech Therapy Hospice No Copay		400.00	no copuly in a nyelenane emec	copuj :jo.o.u cc				
Hearing Alds every 3 yrs 3 yrs ear, once every 3 yrs per ear, onc Physical, Occupational, & \$40.00 \$50.00 Speech Therapy Hospice No Copay No Copay No Copay No Copay No Copay No Copay Retail 30 Day Supply Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill More Delivery Per ear, once every 3 yrs Spocial Supplied and Supplied an	50%	\$50.00	\$40.00 Physician, no copay for nursing services	\$40.00 Physician, no copay for nursing services	Home HealthCare			
Physical, Occupational, & \$40.00 \$40.00 \$50.00 \$50.00 \$60.	y up to \$2500 per	No copay up to \$2500 per yr per	No copay up to \$2500 per yr per ear, once every	No copay up to \$2500 per yr per ear, once	Hearing Alds			
Speech Therapy Hospice No Copay S50.00 S6 Express Scripts Inc - Pharmacy Benefit Manager Retail 30 Day Supply Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill Specialty II Accredo 2 retail fills a Home Delivery	r, once every 3 yrs	ear, once every 3 yrs	3 yrs	every 3 yrs				
No Copay No Copay State	50%	\$50.00	\$40.00	\$40.00	' ' ' '			
Express Scripts Inc - Pharmacy Benefit Manager Retail 30 Day Supply COPAY COINS Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill 30 day fill		•	• • • • • • • • • • • • • • • • • • • •					
Retail COPAY COINS Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill Retail 30 Day Supply Home Delivery 90 Day Supply 2 retail fills them believed the pay Home Delivery price for 30 day fill	50%	No Copay	No Copay	No Copay	Hospice			
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COINS Maintenance meds 3 retail fills, then home delivery required or pay Home Delivery price for 30 day fill Maintenance meds 3 retail fills, then home 90 Day Supply Home Delivery Home Delivery	-		30 Day Supply					
delivery required or pay Home Delivery price for 30 day fill Home Delivery	eredo Pharmacy		Maintenance meds 3 retail fills, then home					
30 day fill Home Delive	I fills allowed, then	90 Day Supply	delivery required or pay Home Delivery price for	CUINS				
Generic \$5,00 \$5,00 \$15.00 \$60	Delivery Required		30 day fili					
Generic \$5,00 \$5,00 \$15.00 \$60			-					
	\$60.00	\$15.00	\$5.00	\$5.00	Generic			
900 \$30 minimum 505.00 505	£0E 00	¢05.00	\$30 minimum	200/	Brand			
Brand 30% \$95.00 \$85	\$85.00	\$49.00	\$90 maximum	30%				
Brand Non-Preferred 40% \$55 minimum \$125,00 \$12:	\$125.00	\$42E.00	\$55 minimum	400/	Brand Non Brafamed			
Brand Non-Preferred 40% \$125.00 \$12.	⊅1∠3.UU	\$1∠5.UU	\$125 maximum	4U %	Drang Ron-Preferreg			

Express Scripts only - DEDUCTIBLE: \$50 PER INDIVIDUAL/\$100 FAMILY APPLIES TO Formulary and Non-Formulary Only

Pharmacy out of pocket is combined with medical to meet total medical out of pocket

If you obtain a brand name medication when a generic is available, you are responsible for the generic copay plus the cost difference between brand and the generic. This does not apply to specialty medications.

Delta Dental PPO New Mexico

	In-Network	Out of Network
Diagnostic & Preventitive Services	100 % (not subject to deductible)	100% **
Basic Services	80 %	55% **
Major Services	60%	35%**
Orthodontic Services		
Children up to 18	75% up to \$2000 lifetime maximum	
Adults 18 and Over	60% up to \$1750 lifetime maximum	
Calendar Year Deductible	\$50 per person, \$150 per family	
Calendar Year Maximum	\$1750 per enrolled person	

**Please contact Delta Dental for service descriptions or further details at 1-877-395-9420

*The payment percentages shown for Out=Of Network services are based on the Maximum approved Fees applicable only to Out of Network Dentists

, , , ,	Vision Service Plan	
	In-Network	Out of Network
Exam every 12 months	\$10	Up to \$35.00
Prescription Lenses every 12 months	\$15	Single Vision up to \$25.00
(Single Vision, Lined bifocal, Lined Trif	focal,	Lined Bifocals up to \$40
Polycarbonate lenses for dependent c	Lined Trifocal up to \$55	
Frame every 24 months	Up to \$130 = 20% off out of pocket expense	Frame up to \$35
Contacts every 12 months	\$110 allowance when contacts are chosen instead of glasses	Contacts up to \$110
	Please contact Vision Service Plan for specific details at 1-800-877-7195	